CIRCLE ONE:
1st Dose 2nd Dose 3rd. Dose
1st Booster 2nd Booster

Jasper County Health Department
COVID-19 Vaccine Consent Form

NAME (Last)	(First)	(M.I.)	**DATE OF BIRTH** month_____ day_____ year _____ Age ____
ADDRESS			**DAYTIME PHONE NUMBER:**
CITY	**STATE**	**ZIP**	**PHYSICIAN:**

	YES	NO
1. Are you feeling sick today? (e.g., cold, fever, acute illness?) *Defer vaccination until after illness*		
2. **Have you experienced a severe allergic reaction to any ingredient of this vaccine? (*messenger ribonucleic acid (mRNA), lipids (SM-102, polyethylene glycol [PEG] polysorbate 2000 dimyristoyl glycerol [DMG], cholesterol, and 1,2-distearoyl-sn-glycero-3-phosphocholine [DSPC]), tromethamine, tromethamine hydrochloride, acetic acid, sodium acetate, and sucrose)*		
3. **Have you experienced a severe allergic reaction to any vaccine or an injectable medication? Or something else such as food, pet environmental or oral medication allergies (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.) **If yes, you will need to stay 30 minutes for observation after vaccination**.		
4. In the past two weeks, have you received any vaccinations or TB skin test?		
5. I am pregnant or breastfeeding, and I have been counseled by my Obstetrician and/or Pediatrician prior to receiving the COVID-19 vaccine.		N/A
6. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?		
7. I have received passive antibody therapy (monoclonal antibodies or convalescent serum) as part of COVID-19 treatment. (COVID-19 Vaccine should be deferred for at leafst 90 days)		
8. Have you received a COVID-19 vaccine? **CIRCLE THE BRAND:** If yes, what brand of COVID-19 vaccine have you been vaccinated for? Pfizer Moderna Johnson&Johnson		
9. Do you have a bleeding disorder or are you on a blood thinner?		
10. Are you immunocompromised or are you on a medicine that affects your immune system?		

CONSENT FOR VACCINATION:

The purpose of the COVID-19 virus vaccine is to reduce the likelihood of contracting COVID-19. **While the FDA has not approved and continues to evaluate its safety and effectiveness, the FDA has authorized the emergency use of it to prevent COVID 19. As of August 23, 2021, Pfizer was FDA approved.**

All vaccines have risks. Possible side effects of the COVID 19 vaccine, while generally inconsequential in adults, can include:

1. Pain, redness or swelling around the vaccination site.
2. Fever, malaise, headache, fatigue, chills, joint pain and muscular aches. There is a remote risk of a severe allergic reaction.
3. There may be risks that are not yet known. The FDA continues to evaluate the vaccine and the known side effects are limited based on current data. Additional side effects may become known as the vaccine is used more widely.

I consent to the administration of two injections of the COVID-19 virus vaccine. I have read the above statement pertaining to COVID-19 virus vaccine and the Fact Sheet from the manufacturer. I have been advised of and understand the risks, side effects, benefits and alternatives to receiving the vaccine. I understand that there may be risks that are not yet known and other remote risks. I understand the conditions under which the vaccine should not be administered and am unaware of the presence of any of these conditions in myself. I have been advised and understand the vaccine is a series of two injections and I intend to complete the series vaccination. **I understand that I am receiving the vaccine voluntarily and that I have the option to accept or refuse the COVID-19 vaccine at any time, for any reason. I understand that I will not realize the benefit of the vaccine if I decline to receive the second injection.**

- I have been provided information on V-Safe, a safety monitoring smartphone-based tool managed by CDC, and VaxText Messaging service for second-dose reminders**.**
- I consent to allow information on this form, as well as the patient registration form, to be entered as necessary in the Illinois Immunization Registry (ICARE).
- I authorize Jasper County Health Department to bill Medicaid, Medicare or my Private Insurance for the administration of this vaccine.
- I authorize Jasper County Health Department to release information regarding my vaccinations to my physician.
- I have had the opportunity to review the Notice of Privacy Practices

Signature: _____ Date: (month ____ day ____ year 202___)

FOR ADMINISTRATIVE USE ONLY

Vaccine	Date Given	Route	Site	Manufacturer	Lot No. \ Exp Date	Name & Title of Vaccine Admini
COVID-19	/ /	IM	R deltoid L deltoid			